Acknowledgement of Notice of Privacy Practices

I, _____, hereby acknowledge that I have received a copy of this practice's Notice of Privacy Practices. I have been given the opportunity to ask any questions I may have regarding this Notice.

Name_____ Date _____

PATIENT DISCLOSURE INSTRUCTIONS

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (*check all that apply*):

☐ Home Telephone _____

- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Written Communication

- ☐ O.K. to mail to my home address
- ☐ O.K. to mail to my work/office address
- ☐ O.K. to fax to number indicated

☐ Work Telephone _____

- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Other (Fax/Cell, etc.) _____

_____

I allow you to give my clinical information to or answer questions from (*check all that apply*):

- ☐ Spouse
- ☐ Parent
- ☐ Child
- ☐ Other (specify): _____
- ☐ None

_____ _____
Patient/Guardian's Signature Date

_____ _____
Print Name Birth date